Self-Harm and Suicide: Beyond Good Intentions

Poole, Robert; Robinson, Catherine

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SELF-HARM AND SUICIDE: BEYOND GOOD INTENTIONS

When pressure mounts to 'do something' about student suicide, institutions may rush to adopt programmes or training which lack empirical validity. **Rob Poole** and **Catherine Robinson** guide us through some of the considerations we should undertake to avoid expensive, potentially unhelpful mistakes

Concern about suicide amongst students has a long history. There are UK publications in scientific journals on the subject back to the 1950s.[1] The avoidable death of a young person is undoubtedly a tragedy. All reasonable efforts should be made to prevent it. However, well-intentioned suicide prevention measures can be counter-productive or harmful in other ways. It is important to follow the evidence when making decisions about institutional responses to concern about young people.

At some times, it has been believed that suicide is especially common amongst students compared with other people of the same age. When this has been systematically examined, it has rarely been demonstrated to be correct. For example, despite high levels of public concern, the most recent UK figures suggest that, in general, students are at lower risk than their contemporaries.[2] Efforts to prevent suicide amongst students should be matched by equal efforts for other young people. Nonetheless, the statistic is no cause for complacency for anyone concerned with student welfare. Suicide is most common amongst older men but rates in young people have been increasing across the world for some years.[3] Furthermore, each suicide affects a large number of people. Bereavement by suicide is especially difficult. Where a student dies, other students, as well as friends and family, will be affected. Some will experience persistent adverse consequences. People who lose someone by suicide are themselves at increased risk.[4]

Assessing what works in suicide prevention is not straight forward. Suicide is an uncommon event, and demonstrating that an intervention has led to a fall (or for that matter an increase) in its incidence is difficult. It is impossible to know whether short-term changes would have occurred by chance unless you apply robust statistical analysis and significance testing. When evaluating low frequency events, the absolute size of any effect must be large in order to achieve statistical significance. This means it is easier to get evidence for factors that affect large populations, such as everyone in England and Wales, than for those that affect relatively small populations, such as students in any individual university. This does not mean that it is impossible to establish an evidence base, but organisations should be cautious before acting on claims based on raw figures that have not been subjected to independent scientific peer review.

Suicide prevention and students

Suicide prevention mostly involves multiple measures, each of relatively small effect. There are well recognised risk factors for suicide, but they tend to affect a large proportion of the population. This means that they are of little help in assessing risk in individuals. Furthermore, despite strenuous efforts over many years, there are no risk instruments that have any utility in everyday life. In fact, such risk instruments are misleading, as they give a false impression of objectivity. As it is difficult to specifically target only those at highest risk, suicide prevention is generally about measures that affect whole groups or populations.

Access to services

In the UK, a high proportion of people who take their own lives are suffering from a diagnosable mental illness.[5] This means that it is important to recognise and treat mental illness. Furthermore, risk is especially high amongst those who survive an attempt to take their own life. Easy access to mental health services when they are needed is therefore important. As anyone involved in student welfare is aware, this is challenging. Students move between university and home, which is disruptive to mental health interventions of all sorts. Student counselling services are a key element in supporting those in distress. They have well-developed expertise and should be easy for students to access. The primary interventions offered by student counselling services are valuable, but they are also skilled in identifying those who have severe problems and need referral to mainstream psychiatric services. To fully exploit this expertise, there must be a pathway for timely assessment by mental health services. This can be difficult to negotiate, and often requires strong

institutional support. For university managers who are pressed to 'do something' about student suicide, supporting student counselling services and referral pathways can seem prosaic or unimaginative, but the fact is that they are important, even if they cannot eliminate all risk.

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Money

We know that in the UK, the suicide rate amongst men closely follows the unemployment rate. We also know that debt is a factor in many suicides.[6] Access to debt advice is valuable, even if it is hard to show that this has an impact on suicide rates. It is something that is of benefit to a large group of people, and the fact that it might have a positive effect on someone at risk of suicide is an added bonus.

As a matter of political policy, there has been a progressive escalation of debt amongst students (especially students from less well-off backgrounds) through the abolition of grants and increases in fees. Although student debt is construed as benign, it is not always experienced like that; the sums involved can be intimidatingly large. It is unclear what the long-term effect of heavy debt will be. In the meantime, we need to support students in managing their money.

Isolation

Isolation is an issue for students who are struggling. It causes unhappiness, but self-isolation is also common when people become low in mood. It is frequently a sign of emerging problems in those who go on to take their own lives. It is sensible for universities to encourage a culture that militates against students slipping into isolation unnoticed, for example, encouraging student peer support, including calling round when people do not turn up as expected.

Alcohol and drugs

There is more public concern about drugs than alcohol. However, there is a strong and specific link between alcohol use, depression, self-harm and suicide.[7] There is also a link with violence, including sexual assaults. It is lamentable that the alcohol industry targets students as a key market. In the UK, the educated middle class is the section of the population with the highest per capita alcohol consumption, and the industry is aware that consumption patterns established at university persist. 'Happy hours' and low cost promotions are not free gifts. They are loss-leader investments in nurturing cohorts of loyal customers.

Universities and student unions should not collude with promotion of drinking, and especially with the provision of low or no cost alcohol. Displaying materials from the alcohol industry's Drinkaware campaign is almost certainly counter-productive. The Alcohol Health Alliance oppose Drinkaware on the grounds it promotes alcohol consumption whilst appearing to warn against 'irresponsible drinking'.[8] The available evidence suggests that campaigns of this type are taken as supportive of one's existing pattern of consumption, no matter how heavy that is. Few people think that they are irresponsible drinkers, and most believe that heavy drinking is a habit of other people. University-wide restrictive or prohibitive alcohol policies may be no fun, but they are as well-founded as no smoking policies.

Means

One might expect that restriction of access to a common means of taking one's own life would simply lead to an immediate change in method. In fact, restriction of access to means has a marked impact on suicide rates.[9] Whilst this effect does not always endure in the long run, it is big enough to mean that many lives are meanwhile saved. Reduced access to means is a very well established suicide prevention measure. The withdrawal of coal gas from domestic gas supplies in the UK in the 1960s was an early example; restriction of paracetamol pack sizes and car exhaust catalytic converters are more recent examples. Restricting student access to means is a challenging task. Limitations on access to toxic over-the-counter medication can be achieved through agreements with shops located within and near to university campuses. Death by ligature has become increasingly common, and tends to occur in domestic settings. Restricting obvious ligature points in halls of residence and provision of collapsing curtain and shower rails may have an impact (as it has in mental health inpatient facilities).

Culture

Suicidal behaviours are not universal. Work on suicide in low and middle income countries (LMICs) shows that, whilst there are some similarities with high income countries (HICs), there are important differences too.[10] For example, suicide rates in India and China are far higher than in the UK. Whilst men

outnumber women amongst suicides in HICs, in south Asia suicide is as common amongst women as men.[11] Methods differ markedly as well, with a high incidence of pesticide ingestion and self-immolation in Asia. Both are rare in HICs.

The presence of many international students in UK institutions therefore represents a particular challenge for student support. Culture affects help-seeking behaviour. Typical expressions of distress differ, as do behaviours indicative of a developing crisis. Isolation is a particular issue for international students, who also face special problems that are invisible to indigenous students. For example, it is evident that, following the Brexit referendum, international students are increasingly exposed to xenophobic or racist behaviours from members of the public. Student societies for particular nationalities cannot provide the totality of support, but they are a good place to start in understanding the adjustments that are necessary to encourage help-seeking.

In loco parentis

There is some ambiguity at present over the nature of the relationship between universities and their students. In bringing together large numbers of young people, most of whom are living away from home for the first time, universities create a social environment that is unusual. It is right that they should accept some responsibility to ensure that their students can access the level of support that they need and could expect if they were not students. The commodification of education means that students are now customers to whom universities owe a duty of care. This can get out of hand to the point where academic institutions may face expectations that they will act *in loco parentis*, as schools must for younger age groups.

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The problem with applying *in loco parentis* to university students is that actual parents have little or no legal responsibility or authority over their offspring aged 18 and above. The concept is essentially infantilising for this age group. The main developmental challenge for undergraduates is independence: intellectual, social and personal. This can cause some turbulence and unhappiness, but trying to keep students frozen at an earlier developmental stage is doomed to failure. On the other hand, obtaining consent on registration from students to contact their parents or specified others in the event that they are distressed or causing concern is sensible in an era when data protection regulations can confound common sense. Of course, this means respecting the students wishes if they withhold or withdraw consent.

Measures that may be unhelpful

The long history of the development of psychological therapies carries a number of salutary lessons about good intentions. A key example is psychological debriefing. This was developed in the 1980s and 90s as a response to disasters. It was based on the belief that an early and assertive effort to help people to work through what had happened would prevent post-traumatic stress disorder (PTSD). It was widely applied, and later rigorously evaluated. This evidence suggests that it is counter-productive and increases the rate of PTSD. In 2012, the World Health Organisation firmly advised against its use.[12] The best available advice is that it is better to wait and see whether the person recovers from their initial distress before intervening.

So good intentions and 'self-evident' rationales must be treated with caution. Unfortunately, the pitfalls for universities are increasing. There are a range of commercial products and schemes offered by charities, community interest companies, private limited companies and others. Some of these are relatively respectable and some of them are not. A few are rather cult-like. It can be very difficult for the non-specialist to distinguish between them. It would be entirely inappropriate for us to endorse (or conversely condemn) any specific organisation or set of ideas, but we can set out some general guidance.

Mindfulness

Mindfulness is a psychological technique based upon elements of Buddhist meditation practice. In the UK it was developed by Dr Mark Williams and colleagues at Bangor and Oxford Universities. There is scientific evidence supporting the usefulness of mindfulness techniques, but mindfulness is not a panacea.[13] There is no real evidence to support a belief that training whole populations in mindfulness will protect them from the impact of tangible stress. In our opinion, this suggestion is positively harmful, insofar as it implies that it is unnecessary to take action to alleviate occupational and social adversity. There is conflicting evidence on possible adverse effects of

mindfulness. It is culture bound, and the connection with Buddhism can have difficult resonances, because all religions have meanings concerning power relationships. For example, Muslim Rohingya in Myanmar are subject to ethnic cleansing in a predominately Buddhist country.

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Compassion

The observation that medical, and particularly nursing, practice can lack compassion has led to the development of a movement to propagate compassionate behaviour amongst the health professions and, more recently, amongst the general population. Some claim to have developed techniques to promote this. Others seek to use spirituality or religion to promote compassion.

Lack of compassion is indeed a problem in many settings, but there are lessons from psychology about the social origins of this, for example, the notorious Zimbardo and Milgram experiments.[14,15] In health settings, staff stress and overwork inhibit compassion. Just like 'irresponsible drinking' mentioned above, 'lack of compassion' is usually identified in other people, not oneself. Consequently, compassion campaigns can appear unattractively self-congratulatory. There is little or no evidence that compassion can be propagated through training, and still less that suicide can be prevented through this.

Suicide awareness training

Suicide awareness training is probably, on balance, a good thing provided it focuses on firmly established evidence rather than unsupported good intentions. It is often possible to access suicide awareness sessions through local mental health professionals at low or no cost. Where suicide awareness is provided to large numbers of people, some will already be at risk of suicide themselves. It is therefore important to avoid providing unhelpful information, such as detailed descriptions of effective methods of taking one's own life. Some courses that are described as suicide awareness training have highly idiosyncratic curricula.

General considerations

How can the likely utility of fee-charging courses offered to your university or students' union be assessed? A few warnings:

1. There is a plethora of suicide prevention guidance, some of which has been developed with the involvement of organisations that have an (often unacknowledged) financial conflict of interests. Apparent high profile endorsement is not enough to confirm that a product is worth purchasing.

2. Declarations that organisations are 'not-for-profit' or 'charity', although usually technically true, are almost meaningless. Individuals can make large sums from community interest companies and charities. Some limited companies make similar claims. This is not to say that all companies that make this claim are being disingenuous, but the declaration in itself is no recommendation.

3. Extravagant claims of changes in occurrence of suicide, self-harm or suicidal thoughts as a consequence of courses should be treated with extreme caution, unless there is evidence available in the public domain from peer-reviewed scientific journals. Claims that such evidence has been gathered but is not yet available in the public domain, or that products are in some unspecified way 'evidence based' or 'peer reviewed' are not, in our opinion, to be trusted. Where proper evaluation has been conducted there will invariably be some disappointing findings, and respectable organisations acknowledge the limitations of what they offer.

4. High costs, and ongoing expense, for example through licensing fees for instruments or further training, should dictate caution. Use of copyrighted materials is a warning sign that there may be hidden costs. Some suicide prevention schemes resemble pyramid selling.

5. Any claim that a scheme is likely to increase efficiency, reduce costs and, most of all, allow disinvestment from existing student support services is highly questionable.

Conclusion

Suicide prevention amongst students is not a new endeavour. It is important to build on existing expertise and not to imagine that this can be replaced by externally-sourced quick fixes. Welfare measures that benefit the entire student body are key, together with pathways to timely assessment by mental health services for that small minority who are at high risk by reason of mental illness.

ABOUT THE AUTHORS

***Rob Poole**, MB BS, FRCPsych, is Professor of Social Psychiatry and Co-Director of the Centre for Mental Health and Society at Bangor University. His clinical work is in liaison psychiatry. His academic interests include clinical skills and suicide prevention. He is a Co-Investigator in the South Asia Self-Harm Initiative.*
rob.poole@wales.nhs.uk

***Catherine A Robinson**, BA, PhD is Professor of Social Care Research and Director of the Personal Social Services Research Unit at the University of Manchester. As an undergraduate, she led a nightline. She now leads international work on suicide prevention and is Principle Investigator of the South Asia Self-Harm Initiative.*

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